

1 professional opinion as to whether Ms. Clark was a
2 candidate for confirmation surgery because you had
3 not seen her in 22 months?

4 A I don't recall, but that would be something that I
5 could see myself saying that -- that I had
6 outlined, you know -- as you established, I had
7 outlined a kind of pathway to reevaluation, and
8 that whole case was so delayed so that almost two
9 years later they asked me the questions so -- and I
10 didn't know what happened to Ms. Clark in the last
11 22 months.

12 Q What is it that makes you feel comfortable
13 rendering an opinion as to whether Autumn is a
14 candidate for confirmation surgery when you have
15 never seen her if you could not make that
16 determination for Ms. Clark because you had not
17 seen her in 22 months?

18 A Did I state that there is -- that this person
19 should not have sex reassignment surgery in my
20 report?

21 Q Do you believe that Autumn should have a pathway
22 available to potentially obtain confirmation
23 surgery in the future?

24 A I would say that any long-term inmate who
25 identifies as transgender and who thinks that

1 gender confirmation surgery is desirable for her
2 ought to have a pathway to a psychotherapeutic,
3 conversational trusted -- with a trusted person --
4 pathway over time to think about this question and
5 to recognize her own ambivalence so that when -- so
6 that she can, in fact, consider multiple things
7 including her background and in this particular
8 case her masochism, her self-hatred, her continued
9 difficulties in interpersonal relationships, and so
10 that I think that a -- that almost everybody
11 deserves an opportunity to think about this over
12 time, over a long period of time, with a trusted
13 person when they can get at the forces, the
14 motivations, for their wish for surgery, their hope
15 for benefits, and their knowledge of the potential
16 harms and the possibility that science would
17 dictate that not everybody achieves their benefits,
18 the desired benefits. So that is a pathway, and in
19 that sense, my answer to your question is yes.

20 Q Do you understand that the Indiana statute that we
21 have challenged in this case makes that pathway
22 unavailable for transgender inmates within the
23 Indiana Department of Correction?

24 A Yes. I now understand that, but the path --
25 what --

1 Q That's all I wanted to ask, Doctor. Thank you.

2 A It's not quite accurate, though.

3 Q Okay. I am just about done with asking my
4 questions, I think. If it's okay with you, Doctor,
5 I would like to take a break, maybe ten minutes or
6 so to speak with my cocounsel.

7 And, Alex, I really think I'm very close to
8 done if you want longer to speak with Dr. Levine or
9 anything.

10 MR. CARLISLE: Okay.

11 (A discussion was held off the record, and a
12 brief recess was taken.)

13 Q Doctor, despite the fact that my cocounsel has
14 temporarily left the room and is now back, I have
15 just two very quick follow-up items for you. The
16 first, the Texas inmate that you testified about in
17 the Norsworthy case, the California case, do you
18 recall that inmate's name?

19 A I was never given a name. I have probably
20 initials. I want you to know that --

21 Q And I'm sorry, Doctor. You answered the question.
22 Who gave you that inmate's initials?

23 A The person who presented the case to me gave me a
24 sheeted -- a printed sheet, rather, with the
25 elements of the presentation. I happen to -- for

1 reasons I don't understand, I happened to have
2 saved that and spoke -- it's always funny to me
3 that the judge said that I fabricated this, and I
4 have in my possession the basis for which I wrote
5 in that case.

6 Q And you indicated that the individual had received
7 gender affirmation surgery while incarcerated in
8 Texas? Do I have that right?

9 A It was my understanding that -- maybe there was
10 some confusion here about vaginoplasty. It was my
11 understanding that this person was in prison for
12 one reason in Texas and had castrated himself. He
13 took off one testis, and he was sent to the
14 hospital, and the naive surgeon heard that he did
15 this for this reason, and he said, let's just
16 finish the job. And so then they took off -- they
17 took both. They took the other testis off.

18 Q Okay. So you don't even know if that person
19 carried a diagnosis of gender dysphoria?

20 A Well, the patient said that he had gender
21 dysphoria, you know.

22 Q But you don't know if they carried the formal
23 diagnosis?

24 A Look, if you want to go downstairs and pull out the
25 form --

1 Q I just want to know as you sit here today, do you
2 know if that person had a formal diagnosis of
3 gender dysphoria?

4 A Well, the -- when the person was transferred to the
5 California institution because the person was known
6 to -- I think had gender dysphoria and had this
7 operation -- I don't know whether they did a
8 vaginoplasty or not. At this moment, I don't know.
9 But the person was housed in the female prison, and
10 that's why they were consulting me because the
11 patient said that she/he didn't know who he was,
12 whether he was a man or a woman and was a
13 behavioral disturbance, and nothing that the mental
14 health professionals had done had calmed this
15 person down. And so it was presenting to the great
16 expert, Dr. Levine, who was coming from
17 California -- coming from Ohio to tell them what to
18 do with this case.

19 Q Were you consulted by Texas officials or by
20 California?

21 A No. No. This was only in Sacramento. This is
22 only for one hour. This whole problem started
23 because I mentioned this in the Norsworthy expert
24 opinion report.

25 Q Okay.

1 A That I wasn't sure that, you know, these people
2 will live happily ever after, and that was my,
3 quote, fabrication.

4 Q Okay. I am sharing with you what I have marked as
5 Exhibit 48. Do you see that on your screen right
6 here?

7 A Yes.

8 Q At the beginning of your deposition, Doctor, you
9 had mentioned that in the lead up to today's
10 deposition you had read an article by Van der
11 Sluis?

12 A Yes, this is the one.

13 Q And others. Is that the article?

14 A And what?

15 Q I said Van der Sluis and others?

16 A Yes. Yes.

17 Q This is the article that you reviewed in advance of
18 today's deposition?

19 A Yes.

20 MR. ROSE: Okay. I have nothing further.
21 Thank you very much for your time, Doctor.

22 MR. CARLISLE: Gavin, I think that should be
23 49.

24 MR. ROSE: Alex, I sent you 48, but I never
25 used it, so you can discard it, or I was trying to

1 make it so we did not have gaps in our numbering.

2 MR. CARLISLE: Okay. So can you send me the
3 new 48 then?

4 MR. ROSE: Yeah. I'm so sorry. We just
5 pulled this during the deposition.

6 MR. CARLISLE: Okay. Perfect.

7 CROSS-EXAMINATION

8 BY MR. CARLISLE:

9 Q Dr. Levine, how are you doing?

10 A I'm pretty good.

11 Q Good.

12 A It's 2:00.

13 Q It's 2:00 so we'll --

14 A I'm a little fatigued. I'm fine.

15 Q All right. Doctor, I want to start with earlier
16 when you were talking with Mr. Rose you were
17 discussing the clinician's role in determining
18 whether the patient is telling the truth before you
19 were cut off. Do you recall that?

20 A Yes.

21 Q What did you want to say before you were cut off?

22 A I wanted to say that in our -- in the international
23 group's involvement in transgender care which
24 largely decide who should have surgery and who
25 should not, we encounter -- we had, in our

1 professional understanding of the differential
2 diagnosis of someone who was requesting hormones
3 and surgery, we had this concept of the true
4 transsexual. The true transsexual is a term
5 derived from Harry Benjamin, who is the father of
6 this whole field. In 1966 he thought he could
7 distinguish varieties of people who should have and
8 shouldn't have surgery, and he called a couple
9 groups of people true transsexuals. But, we,
10 listening to Dr. Benjamin, we believed that there
11 were true transsexuals, that is, people who should
12 have and would automatically benefit from surgery.
13 We kept that concept going for about 15 years. The
14 trouble is that we discovered during the course of
15 our work in the '70s and '80s is that many of the
16 people sounded alike in their history, and they
17 sounded just like Harry Benjamin's descriptions.
18 They sounded just like the early chapters in
19 psychiatric textbooks about transsexualism.

20 And we came to realize based upon
21 confrontation with these patients and then
22 confessions that they were lying about their
23 history. Their history was, in fact, much more
24 variable from one person to another, and this
25 homogenous background was, in fact, false. And so

1 we stopped using the term "true transsexual," and
2 so that's what I wanted to explain, the reason why
3 it's not just making the diagnosis in the
4 psychiatric evaluation. It is to make an
5 assessment about the veracity of what we are told,
6 so sometimes we want to get records from the
7 community. Sometimes we want to talk to the
8 parents. We often want to talk to the parents, and
9 we want -- if there's a wife involved, we want to
10 talk to the wife. So it's not simply like the
11 diagnosis exists, and therefore the treatment has
12 to be given of X, Y, and Z, but their
13 responsibility, the evaluator's responsibility, is
14 to judge over time and not just one time, you see,
15 to judge over time the veracity of the history and
16 how much does that change over time. And it often
17 does change over time, and that's why we think a
18 comprehensive psychiatric evaluation cannot be done
19 in an hour or two hours. It has to be extended
20 over time. That's what I tried to say.

21 Q Okay. In paragraph 44 of your complaint, do you
22 recall discussing the 75 percent figure from the
23 Littman article?

24 A Yes. I was extrapolating. The 75 percent actually
25 should have been 76 percent from her statement that

1 only 24 percent of people went back to the original
2 provider to tell them that they think they should
3 transition, unfortunately. That was the source of
4 the 75 percent. I should have said 24 percent
5 returned in at least the study of 100 people.

6 Q All right. But that figure -- (inaudible)

7 A I'm sorry. That got jumbled.

8 Q Earlier you and Mr. Rose were talking about
9 Exhibit --

10 MR. ROSE: Alex, I'm sorry. You have a bad
11 connection or something. You're really choppy.

12 MR. CARLISLE: Let me try turning my video
13 off.

14 MR. ROSE: That's much better.

15 MR. CARLISLE: Better with the video off?

16 MR. ROSE: Yeah.

17 MR. CARLISLE: Okay.

18 Q Sorry about that. Dr. Levine, earlier you were
19 talking with Mr. Rose about Exhibit 37, the Cecilia
20 article. Do you recall that?

21 A Yes.

22 Q You began to discuss why she was courageous, the
23 author of that article. Can you explain what you
24 wanted to say before you were cut off?

25 A Yes. To me and many other people, this was a key

1 article of breakthrough history of trans care. You
2 see, in 1993 was the first presentation of a review
3 of a large number of surgical -- the results of a
4 large number of surgical experiences primarily
5 Europe, and there was a 70 percent loss to
6 follow-up rate, but nonetheless, the Faflin and
7 Yungi (phonetic) concluded that surgery was an
8 effective treatment, and there was no control, and
9 the idea that you lost 70 percent to follow-up, you
10 didn't know what happened to them, and then you
11 made this conclusion that among the 30 percent, the
12 patients generally without any particular
13 measurement because there wasn't that kind of stuff
14 back in the '80s and '90s, that sex reassignment
15 surgery was really a good treatment.

16 So along comes, almost 20 years later, Cecilia
17 and colleagues' study, and the study was of
18 everyone who has sex reassignment surgery, and the
19 data was not on self-report. The data was on
20 the -- from the national databanks for criminality,
21 for death, for psychiatric hospitalizations, for
22 cancer incidents, and for suicides -- and for
23 suicide and for suicide attempts. So in 2011, she
24 presents this study, and it's free access, so
25 anyone -- there's no pay wall. Anyone can read it

1 who was interested in the study. And it was really
2 impressive that we had data, not subjective data
3 but objective data on these many parameters, and
4 she showed a ten-year graph about the death rate of
5 various people who had sex reassignment surgery,
6 right, and then she gave the causes for it,
7 although she didn't use AIDS as a cause,
8 interestingly enough. And so she showed that there
9 was not only elevated suicide rate that Mr. Rose
10 was asking me about, but there was elevated death
11 rates, in general. There was elevated suicide
12 attempt rates and elevated arrest rates. What I
13 want to emphasize is that Cecilia and colleagues
14 recommended in that article that these people after
15 sex reassignment surgery, which, remember for the
16 last 20 years was thought to be a cure of the
17 problem, she recommended life-long psychiatric care
18 after gender -- sex reassignment surgery, see. So
19 this was just an amazing development in the
20 scientific world of trans care, an ideal
21 30-year-follow-up study, you know, and with data
22 that's objective. She presented this paper at the
23 WPATH meeting, and the following year the 7th
24 Standards of Care came out and didn't even mention
25 this study. And so what we have here is an

1 introduction to the fact that the people who were
2 promulgating and advocating sex reassignment
3 surgery for people weren't paying attention to
4 Cecilia and her crew. And so that's why it's a
5 major study, and that's why I think all of us need
6 to take our hats off to Cecilia and her group and
7 to recognize despite what she might have said,
8 don't interfere with sex reassignment surgery.
9 Don't think this study shows what I think it shows,
10 right? I think we all need to understand what's in
11 the study. So when I educate people about
12 transgender care, I have them read this study.
13 See, it's not what Dr. Levine says. It's what the
14 study shows.

15 So that's what I was cut off from saying, my
16 great respect for Cecilia and her work, you see,
17 and my disagreement about what that study meant in
18 terms of caution. And, I mean, everyone has
19 ignored her recommendations that these people have
20 life-long psychiatric care afterwards. And so when
21 I hear somebody saying, oh, this is a cure for
22 gender dysphoria, I think, well, they didn't read
23 the study, or they didn't remember what Cecilia and
24 her colleagues said, life-long care. That means
25 that they were mentally -- they're still not

1 mentally well, and they need more help than surgery
2 can provide. That's what I wanted to say to
3 Mr. Rose.

4 Q Very good.

5 A If he allowed me.

6 Q Dr. Levine, before our last break, you and Mr. Rose
7 were talking about a pathway, and you indicated you
8 weren't done speaking. What did you want to
9 discuss before you were cut off about the pathway?

10 A I thought Mr. Rose was saying pathway meant that
11 there should be sex reassignment surgery given to
12 prisoners, and my concept of a pathway is different
13 than his concept. My concept of a pathway towards
14 sex reassignment surgery would be that if we knew
15 someone wanted sex reassignment surgery who had
16 this diagnosis, that we would enter into a process
17 of talking over time, hopefully gaining the trust
18 of the person, to review the motives for sex
19 reassignment surgery, why they're in such distress,
20 and why do they think the surgery will fix their
21 distress when they only have genital dysphonia, for
22 example, and that we need to think about what their
23 hope for benefits are from the surgery and what the
24 harms that they know about could come from it. And
25 we need to teach them about what the state of

1 science is about this, you see, and we need to
2 recognize that for Autumn, who's going to get out
3 of prison one day, that this preparation while in
4 prison is a pathway towards the eventual decision
5 outside of prison to have or not to have sex
6 reassignment, genital vaginoplasty. So the pathway
7 is, to me, it's a psychological process that
8 requires a trusted relationship to discuss a number
9 of things to meet the legal criteria of informed
10 consent. And, you know, when someone is involved
11 in a lawsuit, they have to represent themselves as
12 they have no ambivalence, but I can tell you as I
13 have told many, many people, transsexual people are
14 first human beings, and human beings are ambivalent
15 about most major things in their life, but they
16 don't necessarily represent their ambivalence.

17 When I talk about a pathway with a trusted
18 relationship to a therapist, it's the therapist is
19 going to teach this person that it's okay to be
20 ambivalent. You can be worried about this. You
21 could be frightened about this. You can have a
22 panic attack about this and still decide in the
23 future to have this surgery, but you need to
24 understand what the anxiety, what the panic is
25 about, you see. And we doctors can't tell you

1 because we don't have the scientific basis to tell
2 you don't worry, dear, this will be fine. We can't
3 say that, and we shouldn't be necessarily
4 deliberately recommending surgery to people that we
5 don't know in this way that you can only know in a
6 pathway towards. A pathway doesn't mean that
7 you're going to get there or that you actually will
8 want to get there when you can get there, and so I
9 think Mr. Rose was using the term pathway as a
10 direct road to the operating table, whereas I think
11 the pathway is the psychological process of
12 thinking about one's life and one's future and
13 trying to be realistic based upon science and based
14 upon my desire and in understanding of the
15 motivation for my desire because, see, people who
16 are transgender or who meet the criteria for gender
17 dysphoria have long been gender dysphoric. They
18 have long been uncomfortable with their body, and
19 suddenly relatively recently they suddenly want
20 surgery.

21 And I want to know how you got from being
22 comfortable taking hormones, you see, and feeling
23 better about yourself and what is causing you to
24 think this is the next step, and are you being
25 manipulated by some legal process, you know, that

1 makes you say I have no ambivalence. That's what I
2 wanted.

3 Q Thank you. Sir, given the state of science, is
4 there a debate within the medical community that
5 surgery -- as to whether surgery is a necessary or
6 effective treatment option?

7 A There's considerable debate. You see, WPATH wants
8 everyone to realize that -- wants everyone to think
9 medical professionals agree that this is the right
10 thing to do for these patients. But when I
11 mentioned those two studies, the Branstrom,
12 Pachankis, and Almazan and Keuroghlian study, what
13 I wanted to emphasize, that these four people who
14 are known from other publications to be staunch
15 advocates for sex reassignment surgery, they said
16 in the introduction to each of their respected
17 papers that it's not clear what the mental health
18 benefits of sex reassignment surgery are, or in
19 this case, we talk about vaginoplasty.

20 But it's not clear what the mental health
21 long-term benefits are. Now, these are not coming
22 from skeptics. These are coming from advocates, so
23 they undertook this study to prove that there was
24 benefit. And, see, the Almazan study -- and
25 Almazan is a medical student, I think -- the

1 Almazan study showed that there was no change --
2 that there was a decrease in suicidal ideation, but
3 there was no change in suicide attempts, so to me
4 these are kind of incongruent ideas. But the most
5 important thing is not that study because that
6 study has a long history of these -- this 227,000
7 people. Many very cogent methodologists have
8 reviewed and trashed any of the studies that come
9 from that population. It's the Branstrom and
10 Pachankis study that we should talk about, you see,
11 because they concluded that sex reassignment
12 surgery had mental health benefits. They published
13 that study online, I think, in December 2019, and
14 immediately upon publication there were seven
15 letters written to the editor by a total of 12
16 authors, and the editor is Ned Kalin from The
17 American Journal of Psychiatry, and Dr. Kalin read
18 these letters and decided to send that study out to
19 two separate statisticians, methodologists. And
20 because the seven letters to the editor says this
21 is junk, the conclusions are not based on the data
22 that is presented, and, in fact, one or two people
23 suggested that the authors were being consciously
24 dishonest.

25 The two independent scientists who looked at

1 this independently concluded that the data did not
2 support the conclusions. Dr. Kalin then decided --
3 he wrote to the authors, and he said you must
4 publish a retraction. So what I think -- so a
5 little background for this. When a journal
6 receives a paper, like The American Journal of
7 Psychiatry received this paper, usually the editor
8 sends it out to three different reviewers, and they
9 must have read this article, and they said that you
10 should publish this article, right? Then what
11 happened happened, what I just described. You see,
12 so what happened is that then the -- when this was
13 published in print -- and that would be August of
14 2020 -- Dr. Kalin then wrote an editorial about
15 what he did and what his concerns had been, and
16 then he talked about the two statisticians. And he
17 published the 7 letters by 12 authors, and he
18 published the retraction of the conclusions by
19 Branstrom and Pachankis, and what they agreed to is
20 that more research is necessary to determine the
21 mental health benefits of sex reassignment surgery
22 and that they agree that their study did not answer
23 all the questions that they thought it answered.

24 And so I tell you this long -- these multiple
25 paragraphs I just uttered to say to you there are

1 doctors who are skeptical about this and doctors
2 who are believers about this. And the state of
3 science is uncertain. That's, of course, what the
4 Medicare review in 2016 said and that, I think,
5 prudent, intelligent, thoughtful people can
6 disagree.

7 Now, in medicine, disagreement is common, and
8 we use disagreement to articulate further studies,
9 to design further studies to settle the
10 controversy. In this field, we don't do -- we
11 don't settle our arguments. We just sort of hate
12 each other. We sort of have animus for one
13 another. We select studies, so this state of
14 disagreement here is so unlike any other medical
15 issue, you see, and it should alert all of us
16 there's something strange going on here where
17 science is not respected by people. I think that's
18 what I wanted to tell Mr. Rose.

19 Q Very good. Given the state of science you just
20 described, are there treatment options for gender
21 dysphoria currently available within the Indiana
22 Department of Correction sufficient to treat
23 prisoners with gender dysphoria even if surgery is
24 not an option?

25 A As far as I understand, IDOC recognizes that this

1 is a particular psychiatric disorder and that it
2 has accommodations that can be done to ease the
3 pain and suffering and distress of people. And,
4 you know, those are the things that WPATH has
5 written about in SOC8, that is, that we should
6 address them as they wish to be addressed with
7 pronouns of her, you know, and if I say my name is
8 Autumn, call me Autumn. They're called Autumn,
9 right? They get the showers separately. They get
10 female canteen items. They get evaluated and can
11 obtain estrogen treatment, estrogen and puberty
12 blockers, spironolactone. And they're generally
13 accommodated very nicely to this, and hopefully all
14 the things that they want make them temporarily
15 feel better, you see.

16 So given the uncertainty about sex
17 reassignment surgery having additional long-term,
18 lasting benefits that prevent suicide and prevent
19 depression and despair, you see, and given the
20 politics that determine whatever state legislatures
21 decide or the DOC decide, I think Indiana DOC is
22 indicating that they recognize gender dysphoria as
23 a problem. They recognize there's some things to
24 do to make these chronically disturbed people --
25 many of them chronically disturbed people -- a

1 little more comfortable. And I think they make
2 this a policy. And does that mean it cures all
3 their distress about living in their body and
4 living with their adversities and their crimes and
5 so forth? No. But I think Indiana is trying to do
6 something to help them, you see, within the
7 limitations of the law, within the limitations of
8 medical uncertainty. You see, even the fact
9 whether hormones really improves males with gender
10 dysphoria has not been adequately proven. It's
11 just the fashion to do it, but the fashion of
12 giving hormones which can be stopped and the body
13 can -- at least the male body can return to some
14 male function, is different than having a surgery
15 that you can't reverse, you see, so I think that's
16 one of the reasons why these DOCs easily provides
17 hormones these days but don't easily provide sex
18 reassignment genital surgery because of the
19 irreversibility and the -- of the procedure. And
20 the recognized -- the recognized vulnerabilities of
21 these people because, you know, they have
22 borderline personality disorder. They have
23 self-harming behaviors. They are sociopathic.
24 These are -- all these are indications that I don't
25 cope well with life, with my feelings, and my

1 dilemmas, so I think the DOC is trying to treat
2 these people, including Autumn. I don't think
3 they're indifferent to Autumn's pain.

4 MR. CARLISLE: Very good. Thank you,
5 Dr. Levine. That's all the questions I have.

6 REDIRECT EXAMINATION

7 BY MR. ROSE:

8 Q Doctor, I just have one very quick follow-up. Both
9 with me initially and then with Alex you were
10 discussing what we called a pathway to, however you
11 want to phrase it, to gender-confirming surgery, to
12 consideration for gender-confirming surgery. I
13 don't want to -- I don't want anyone to get bogged
14 down in semantics. In your estimation, in the
15 appropriate patient, is it possible that this
16 pathway could eventually lead to the provision of
17 gender confirmation surgery for prisoners?

18 A For prisoners? Well, the answer is potentially
19 yes.

20 MR. ROSE: Okay. Thank you. I have nothing
21 further.

22 RECROSS-EXAMINATION

23 BY MR. CARLISLE:

24 Q Was there anything you wanted to add on that before
25 we end today?

1 A Are you talking to me? Anything I wanted to add?

2 MR. ROSE: I'm going to object. That's not a
3 proper question.

4 Q Were you done speaking?

5 A I'm sorry. I didn't quite understand. Were you
6 asking me, Alex?

7 Q Yes, Dr. Levine. Were you done speaking?

8 MR. ROSE: Sorry, Alex. I asked a yes or no
9 question and got an answer. If you have a real
10 question, you can ask it, but that's not a proper
11 question either here or in court.

12 Q Did you want to explain that answer?

13 A Oh.

14 Q It seems like you were about to speak. That's all
15 I'm asking. If you don't, that's fine, and we can
16 end. I just want --

17 A No. You know, I would be happy to elaborate that
18 because, you know, the whole nature of the
19 deposition is to force me to answer yes and no to
20 things that are profoundly complicated. And I
21 gather that's -- the purpose of that is for the
22 trial. But the -- what I want to say is that
23 theoretically there could be a person who is in
24 prison who -- that the psychological pathway of
25 ensuring informed consent and increasing maturation

1 and improving coping capacities of that person to
2 deal with this life and recognizing the impact of
3 the past on his present distress, you see,
4 theoretically, it is possible that in a state that
5 allows that like Massachusetts or California, that
6 with the proper preparation, if the patient
7 persists in requesting sex reassignment surgery, I
8 think it's reasonable for that particular person.
9 But that is different than all people with gender
10 dysphoria ought to have a pathway to this, you see,
11 to surgery. Mr. Rose asked me basically on a
12 theoretical sense given the fact that I believe if
13 a pathway exists, so I said yes, but I don't know
14 how frequently that would happen given what I
15 understand about the associated psychopathologies
16 and the numerous adversities of these prisoners
17 that I have seen over the 17 years working with
18 prisoners have.

19 And if you recall the Osborne and Lawrence
20 study, they too had a lot of criteria that had to
21 be met before they would even consider it, but they
22 thought it was -- they would have given the same
23 answer that I gave to Mr. Rose. Theoretically
24 there's a person who might have qualified for it
25 and it would be reasonable but not most of them.

1 That's what I wanted to say. I think you guys are
2 done with me.

3 MR. ROSE: I think so. Thank you for your
4 time today, Doctor.

5 THE WITNESS: I hope you're hungry, all of
6 you. Bye, everyone. Are you and I done now, Alex?

7 MR. CARLISLE: I have one more question. Do
8 you want to review the transcript and sign off on
9 it, or do you want to waive that opportunity? It
10 doesn't matter to me.

11 THE WITNESS: I would prefer to waive the
12 opportunity just because it's just too difficult,
13 too boring.

14 MR. CARLISLE: All right. We will waive
15 signature then.

16 THE WITNESS: Thank you.

17 MR. CARLISLE: That's all I have for you,
18 Doctor.

19 THE WITNESS: All right. Good afternoon,
20 everyone.

21 MR. ROSE: Take care Doctor. Thank you.

22 And, Madam Court Reporter, you remember that we
23 asked for a rush for this week?

24 THE REPORTER: Yes. So an electronic delivery
25 Friday would be okay?

1 MR. ROSE: That's perfectly fine. Thank you.

2 THE REPORTER: That's no problem.

3 Mr. Carlisle, do you need a copy?

4 MR. CARLISLE: Yes, please.

5 THE REPORTER: E-Tran?

6 MR. CARLISLE: E-Tran is fine.

7 THE REPORTER: Do you also need it by Friday
8 or just regular?

9 MR. CARLISLE: Just regular.

10 AND FURTHER THE DEPONENT SAITH NOT.

11

12 (Signature waived)
13 STEPHEN BARRETT LEVINE, MD

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1 STATE OF INDIANA)
2) SS:
3 COUNTY OF JOHNSON)

4 I, Gretchen Fox, RPR, a Notary Public in and
5 for the County of Johnson, State of Indiana at large,
6 do hereby certify that STEPHEN BARRETT LEVINE, MD, the
7 deponent herein, was by me first duly sworn to tell
8 the truth, the whole truth, and nothing but the truth
9 in above-captioned cause.

10 That the foregoing deposition was taken on
11 behalf of the Plaintiff remotely via Zoom
12 videoconference on the 7th day of February, 2024,
13 pursuant to the Applicable Rules.

14 That said deposition was taken down in
15 stenograph notes and afterwards reduced to typewriting
16 under my direction, and that the typewritten
17 transcript is a true record of the testimony given by
18 said deponent; and that the signature of said deponent
19 to his/her deposition was waived by the deponent and
20 all parties present, the deposition to be read with
21 the same force and effect as if signed by him/her.

22 That the parties were represented by their
23 aforementioned counsel;

24 I do further certify that I am a disinterested
25 person in this cause of action; that I am not a
relative or attorney of either party, or otherwise

1 interested in the event of this action, and am not in
2 the employ of the attorneys for either party.

3 IN WITNESS WHEREOF, I have hereunto set my
4 hand and affixed my notarial seal this _____ day of
5 _____, 2024.

6
7 _____
Gretchen Fox

8
9 Commission Number 066154

10 My Commission Expires:
11 January 25, 2031
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COMMISSIONER, INDIANA DEPARTMENT OF CORRECTION

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